DPHHS LATENT TB INFECTION (LTBI) TREATMENT PROGRAM
Payer of Last Resort

Department of Public Health & Human Service
TB Program
Cogswell Building, Room C-216
1400 Broadway, Helena, MT 59620
Phone: 406-444-0274; Fax: 800-616-7460

Today's date: ______________________

Submitted by: ______________________

Agency: ______________________

Phone: ______________________

<u>Local Health Department</u>: *Please mail or fax a copy of this form along with the prescription(s) to the TB Program to initiate treatment <u>and</u> mail or fax the completed form again upon completion or termination of treatment.*

Patient Name: ______________________
Address: ______________________ City: ______________________
DOB: __________ Sex: ______ Race: ______________________
Occupation: __________________ Employer: ______________________
Attending Physician: __________________ Phone: ______________________
Public Health Manager: __________________ Allergies: NKA ( ) List allergies: ______________

Does the patient have insurance: Yes ( ) No ( ) Does the patient have Medicaid: Yes ( ) No ( )

1. **Reason for TB Testing**: ( ) Contact of known TB case; Name of case ______________________
( ) Foreign born; Country of origin ______________________
( ) Occupational ______________________
( ) Other ______________________

2. **Tuberculin Skin Test / IGRA (QFT or T-Spot) Result:**
Signs/Symptoms consistent with active disease: Yes ( ) No ( ) TST Date: ________ QFT Date: ________
Induration in mm: ______ Quantitative result: ______ ( ) Positive ( ) Negative
Health-care person placing/reading: ______________ Lab: ______________________

3. **X-ray**:
Date: ______________ Where was it done? ______________________
Result: ______________________

4. **Bacteriological Status**: (Smear or culture results if collected)
   Smear: Date: ______ Result: ______________________
   Culture: Date: ______ Result: ______________________

5. **Latent TB Infection Therapy**:
   Start date:
   Treatment regimen: ( ) INH, 9 mo; ( ) INH, 6 mo; ( ) RIF, 4 mo; ( ) INH/RIFAPENTINE**,** 12 week

<u>When patient completes or otherwise ends treatment of LTBI fill out this section and mail or fax the entire form to the TB Program at DPHHS</u>

Treatment completion date: ______________________
If treatment is not completed, discontinued date: ______________
If discontinued, reason:
___ Diagnosed with active TB
___ Medical suspension due to adverse reaction
___ Moved, records referred to:
____
___ Noncompliant
___ Lost to follow up
___ Death

By signing below, I certify that to the best of my knowledge the patient above does not have other means to pay for medication or that the deductible is too great a financial burden for the patient to bare.

Submitted by: ______________ Agency: ______________ Today's Date: ______________